

Congress of the United States
Washington, DC 20515

January 22, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington DC 20201

Dear Administrator Tavenner,

As you know, Congress enacted significant changes to long-term care hospitals (LTCHs) in the *Bipartisan Budget Act of 2013* (P.L.113-67). In this legislation, Congress recognized the unique situation of a certain type of hospital currently classified by the Medicare program as long-term care hospitals, and so directed the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) to evaluate the treatment of this kind of hospital and adjust payment and regulations as necessary. We urge you to implement this provision in concert with new LTCH regulations, in a way that meets the needs of any hospital in this situation and allows them to continue serving their community.

Currently, while most LTCHs are classified under Section 1886(1)(B)(I) of the Social Security Act, subsection (II) refers to a hospital that serves primarily patients with diseases like cancer, and is subject to a different statutory requirement for average length of stay than is applicable to subsection (I) hospitals. Patients at this type of hospital tend to either have very long stays or pass away while at the hospital. This differs from the patient population served by most LTCHs, which seek to stabilize patients and eventually discharge them.

Because a hospital under subsection (II), by definition, has such different needs in terms of patient stay and type of care needed, CMS has long appropriately maintained an exclusion from some of the reimbursement rules applicable to other LTCHs. Were it not for this exclusion, a hospital under subsection (II) would see severe financial losses due to incentives toward discharges contained in the current payment structure. However, the changes made to the LTCH program in P.L.113-67 would worsen this situation, because a hospital under subsection (II) would not meet the requirements for long-term care reimbursement.

In particular, the new law requires that patients admitted to a long-term care hospital have a minimum 3-day stay in an intensive care unit of a "subsection (d)" acute hospital prior to admission to a long-term care hospital or, after admission to a long-term care hospital, receive mechanical ventilator life support for no less than 96 hours. However, the patients at a hospital classified under subsection (II) have a different course of care prior to admission. They typically do not use intensive care units in acute care hospitals before arriving at the subsection (II) hospital, and many times do not use ventilators after admission.

Additionally, the new LTCH admission standards contained in P.L.113-67 do not take into account the direct admission of patients to LTCHs with no prior immediate acute hospital stay. For example, Calvary Hospital in the Bronx, New York, which is classified under subsection (II), in 2013 admitted approximately 40% of its patients directly with no immediately prior short-term acute hospital stay. As such, Congress recognized that this new LTCH criteria is not appropriate for a hospital under subsection (II) and expressly gave authority for a hospital under this subsection to be treated differently.

This issue is of particular concern to us because subsection (II) applies to Calvary Hospital, one of New York's premier facilities for end-of-life care. For nearly 115 years, Calvary has admitted predominately end-stage cancer patients, who have little likelihood of survival and require more serious care than at-home hospice or skilled nursing facilities can provide. With this care, Calvary provides a critical resource to New York City and the surrounding areas. For many of our constituents, Calvary has provided comfort and delivered quality care for severely ill family members. It is important for the Secretary to exercise the discretion that Congress has provided with regards to subsection (II) hospitals in order to avoid severe disruption to the critically ill patient population throughout the New York area that rely upon the Calvary Hospital for services.

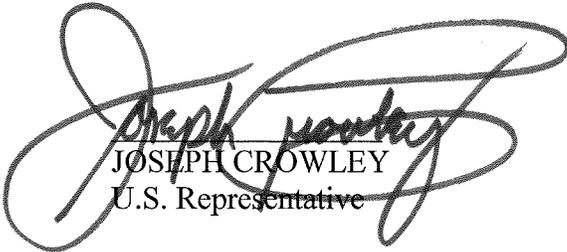
In order for a hospital like Calvary to continue its mission, Medicare payment policies must reflect their actual patient mix and the care they provide. This is why a hospital under subsection (II) deserves continued separation from other LTCHs. We strongly feel that given the forthcoming changes to the LTCH program, it is most appropriate that CMS restore this type of hospital to payment under the model set forth in the Tax Equity and Fiscal Responsibility Act (TEFRA)

The new law authorizes the Secretary to apply different payment and patient selection standards to subsection (II) hospitals and, particularly, to make payment under the cost-based TEFRA payment system that was in effect for this group of hospitals in the past. The Secretary was authorized to make these changes as part of the fiscal year 2015 or 2016 annual Medicare rulemaking. We believe that returning this type of hospital to the TEFRA model, and not limiting a subsection (II) hospital to payment for only patients admitted from an acute subsection (d) hospital, is the best option, for not just Calvary and its patients, but also the Medicare Trust Fund, as it maintains a care option that is more appropriate for these critically ill patients than acute care hospitals. Analyses have shown that if the cases admitted to a hospital like Calvary were instead kept in acute care hospitals, it would result in additional costs to the Medicare program. These savings would remain even under the TEFRA system of reimbursement.

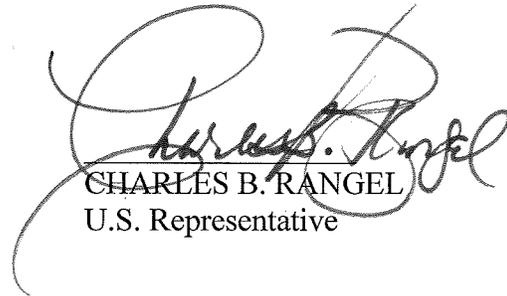
P.L. 113-67 reflects the clear intent of Congress in passing this legislation by specifically mentioning the TEFRA model as a recommended alternative to the LTCH classification. We hope CMS will recognize these merits and shift this category of hospitals to TEFRA, or at the very least, develop an alternative payment policy that strengthens and supports these hospitals. We further wish to underscore the need to address this issue in the FY 2015 Medicare rule making which is currently under development by the Department of Health and Human Services.

Thank you for your attention to this matter. We look forward to working with you and CMS to ensure that the Medicare program is able to provide a stable and predictable payment system for a hospital like Calvary that is so important to our constituents.

Sincerely,



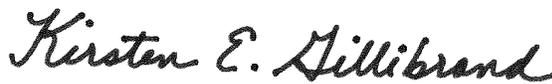
JOSEPH CROWLEY
U.S. Representative



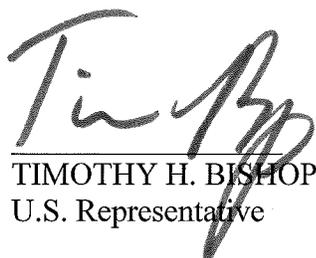
CHARLES B. RANGEL
U.S. Representative



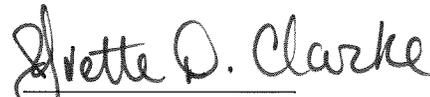
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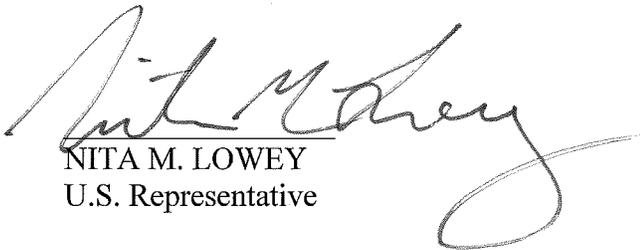
MICHAEL G. GRIMM
U.S. Representative



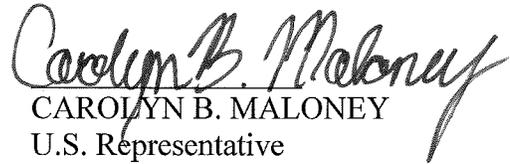
STEVE ISRAEL
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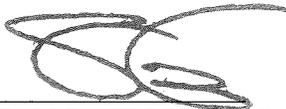
PETER T. KING
U.S. Representative



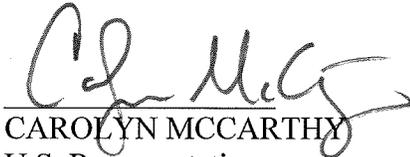
NITA M. LOWEY
U.S. Representative



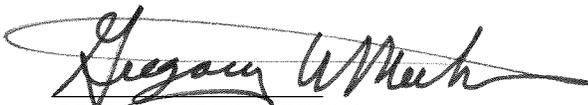
CAROLYN B. MALONEY
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